Offices at Cranbrook ▫ 10111 East 21st Street North ▫ Suite 301 ▫ Wichita, KS 67206

316-634-0060 ▫ 316-634-0050 (fax) ▫ cwhwichita.com

PATIENT INFORMATION

Last Name:	**First Name:**		
Address:	City:	State:	Zip Code:
Phone Number:	Marital Status:	Social Security Number:	
Primary Care Provider:	DOB:	Referring Physician:	
Email Address:		Significant Other's Name:	
Place of employment:			
Ethnicity:		Primary Language:	
Preferred Pharmacy:			

INSURANCE INFORMATION:

Primary Carrier:	Policy Holder's Name/D.O.B.: ☐ Self
Member ID:	Group Number:
Medical Claims PO Box:	

CONSENT TO TREATMENT:

I hereby grant consent for treatment or services to be provided by the providers of Center for Women's Health. I also certify that no guarantee or assurance has been made regarding the result that may be obtained.

QUEST DIAGNOSTICS:

Center for Women's Health uses Quest Diagnostics as our in-office laboratory vendor. Laboratory services including blood draw, pap smears, cultures or biopsies done in our office will be sent to Quest Diagnostics.

It is your responsibility to know if Quest Diagnostics is your in-network laboratory vendor.

If you do not want your laboratory services to be sent to Quest Diagnostics, please write your preferred laboratory vendor name below. We may be able to schedule a pick up for this specimen, otherwise you will need to take the lab order to your designated laboratory vendor.

Preferred Laboratory Vendor:

By signing this form, you acknowledge that you have consented to treatment as stated above as well as to using Quest Diagnostics as your laboratory vendor, unless you listed an alternative vendor.

Patient Signature:	**Date:**
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:
☐ Updated. Signature:	Date:

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ANNUAL GYNECOLOGICAL UPDATE

Name: ______________________ DOB: __________ Today's Date: __________

Welcome Back! Please take a few minutes to fill out this form to help us update your records.

Please check the reason for your visit: ☐ Annual Exam ☐ Problem

Would you like to be tested for sexually transmitted infections? ***Y/N***

Who is your primary care physician? ______________________

What was the first day of your last period? ______________________

Are your periods regular: ***Y/N*** How many days in a cycle? __________

How heavy is the bleeding? __________ How many days of bleeding: __________

Are you sexually active? ***Y/N*** (if yes) Do you have pain with intercourse: ***Y/N***

Please list any new medical problems: ______________________

Please list any surgeries you had since your last visit: ______________________

Any new medical problems in your family? ______________________

Prescription Medications / dosages: ☐ check if none

____
____
____

Supplements & over the counter meds: ☐ check if none

____
____
____

Please list any allergies you have: ______________________

Do you smoke: ***Y/N*** How much: ________ Do you drink alcohol: ***Y/N*** How much per week? ________

Do you use street drugs: ***Y/N*** __________ Do you have problems with violence at home: ***Y/N***

Do you exercise regularly? ***Y/N***

Do you wear sunscreen? ***Always / Usually /Sometimes / Never***
Are you exposed to occupational or recreational hazards? ***Y/N***

Do you wear your seatbelt while riding or driving in a car? ***Always / Usually /Sometimes / Never***

Do you perform monthly self breast examinations? ***Y/N***

What is your birth Control Method: (please circle) none, condoms, spermicidal, foam, Depo-Provera, IUD(Mirena), IUD(Paraguard), , Nexplanon, birth control pills, birth control patch, birth control ring, tubal ligation, vasectomy Other__________
Are you satisfied with this method? ***Y/N***

If not done in our office:

Date of last pap smear: ________ Normal: ***Y/N*** if no, results __________

Date of last Mammogram: ________ Normal: ***Y/N*** if no, results __________

Date of bone density: ________ Normal: ***Y/N*** if no, results __________

Have you had any blood work, labs or x-rays in the past year? ***Y/N*** If so, please list: __________

____

When was your last Tetanus vaccine? ________ Have you had the HPV vaccine? ________

For those over 50, when did you have your last sigmoidoscopy / colonoscopy: ________

PATIENT NAME: ______________________________ **DATE:** ____________

REASON FOR TODAYS VISIT: ______________________________ **LMP:** ____________

GENERAL:
- ☐ Weight loss
- ☐ Weight Gain
- ☐ Fever/ Chills
- ☐ Fatigue/ Weakness

SKIN:
- ☐ Nail Changes
- ☐ Hair Changes
- ☐ Mole Changes
- ☐ Skin Rashes
- ☐ Itchy Skin

EYES:
- ☐ Blurred/ Double Vision
- ☐ Glaucoma/ Cataracts
- ☐ Dry/ Itchy eyes
- ☐ Eye Glasses/Contact Lenses

EARS:
- ☐ Hard of Hearing
- ☐ Hearing Changes/ Deafness
- ☐ Ringing in Ears
- ☐ Ear Discharge
- ☐ Earache
- ☐ Dizziness

NOSE:
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip

MOUTH:
- ☐ Bleeding Gums
- ☐ Oral sores/ulcers
- ☐ Dental Problems
- ☐ Loss of Taste

THROAT:
- ☐ Difficulty Swallowing
- ☐ Throat Pain
- ☐ Hoarseness

NECK:
- ☐ Stiffness
- ☐ Soreness
- ☐ Pain
- ☐ Masses

BREAST:
- ☐ Nipple Discharge
- ☐ Lumps/Nodules
- ☐ Pain/Tenderness
- ☐ Breast Masses
- ☐ Nipple Bleeding

LUNGS:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

HEART:
- ☐ Murmur
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Chest Pain

GASTROINTESTINAL:
- ☐ Change in Appetite
- ☐ Difficulty Swallowing
- ☐ Abdominal Pain
- ☐ Nausea/ Vomiting
- ☐ Bloating/ Gas
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal Bleeding

GENITOURINARY:
- ☐ Urgency
- ☐ Incontinence
- ☐ Frequency
- ☐ Pain with Urination
- ☐ Bloody Urine
- ☐ Urination at Night

BLOOD:
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ Swollen Lymph Nodes
- ☐ Painful Lymph Nodes

GYNECOLOGIC:
- ☐ Break Through Bleeding
- ☐ Labial Sores
- ☐ Labial lumps/nodules
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Painful Intercourse
- ☐ Menstrual Cramps
- ☐ Pain Between Periods
- ☐ Postmenopausal Bleeding
- ☐ Irregular menses
- ☐ Loss of Sexual Desire
- ☐ Night Sweats
- ☐ Vaginal Odor
- ☐ Pelvic Pain
- ☐ Infertility

MUSCULOSKELTAL:
- ☐ Muscle Pain/Cramps
- ☐ Weakness
- ☐ Joint Pain/Swelling

NEUROLOGICAL:
- ☐ Seizures
- ☐ Vertigo
- ☐ Paralysis
- ☐ Tingling/Numbness

PSYCHIATRIC:
- ☐ Depression
- ☐ Irritability
- ☐ Anxiousness
- ☐ Alcohol Abuse
- ☐ Suicidal Thoughts
- ☐ Sexual Difficulties
- ☐ Panic Attack
- ☐ Drug Addiction
- ☐ Physical Abuse

ENDOCRINE:
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Loss of Hair
- ☐ Extreme Thirst
- ☐ Excessive Hair Growth
- ☐ Hypoglycemia/Low Blood Sugar

OTHER CONCERNS:

____
____
____
____
____
____
____
____
____

Family History Screening Form

Patient Name: ______________________________Date of Birth: _________ Age: ____ Height: ______ Weight: ______
Your age at First Period: _____ Your age at First Childbirth (if applicable):_______ Are you Menopausal: Yes or No
If yes, your age at Menopause: _____ Have you ever used Hormone Replacement Therapy? Yes or No If yes, for how long? _____
Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please indicate if you have a **personal or family history** of any of the following cancers. If yes, then **write family relationship** and **AGE at diagnosis**. **Consider parents, children, brothers, sisters, half- siblings, grandparents, aunts, uncles, nieces, nephews.**

BREAST AND OVARIAN CANCER (HBOC)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	**EXAMPLE:** *Breast Cancer*	———	———	*Aunt 53*	*Grandmother 45*
Y	N	**Breast Cancer**				
Y	N	**Breast Cancer in both breasts OR multiple primary breast cancers**				
Y	N	**Ovarian cancer** *(Peritoneal/Fallopian Tube)*				
Y	N	**Male breast cancer**				
Y	N	**Are you of Ashkenazi Jewish descent?**				

COLON AND UTERINE CANCER (LYNCH)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	N	**Endometrial (uterine) cancer**				
Y	N	**Colon/Rectal cancer**				
Y	N	**Ovarian, stomach, kidney, brain OR small bowel cancer** **Please specify relatives, type of cancer & their age at diagnosis.*				
Y	N	**10 or more colon polyps in a lifetime** *(Specify #)*				

Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Melanoma (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lynch)**				
Y	N	**Other Cancers** **Please specify relatives, type of cancer & their age at diagnosis.*				

Patient's Signature: ______________________________ Date: __________

For Office Use Only:
Patient offered hereditary cancer testing? HEALTH CARE PROVIDER SIGNATURE: ____________________
☐ YES ACCEPTED DECLINED
☐ NO

1st degree: self, parents, siblings, children. 2nd degree: grandparents, grandchildren aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.

HBOC - Personal or Family History

One person with: (out to 2nd degree)
-Breast (diagnosed <50)
-Ovarian, ANY age
-Male breast, ANY age
-Breast with Ashkenazi Jewish heritage, any age
-Bilateral breast at ANY age
-Triple Negative breast (diagnosed ≤60)
-Metastatic Prostate or Pancreatic at ANY Age
-Metastatic Breast at ANY age (personal history only)

Two persons with: (out to 3rd degree)
-Breast cancer (1 diagnosed ≤ 50)
-Breast & Ovarian Cancer, any age

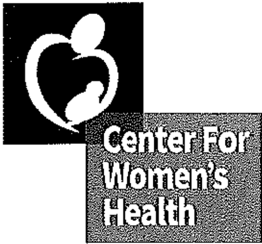
Three Persons with: (out to 3rd degree)
-Breast and/or Pancreatic and/or Prostate, any age

Lynch*- Personal or Family History

One or Two persons with: (out to 2nd degree)
-Endometrial or Colorectal cancer (1 diagnosed ≤50)
-Endometrial or CRC cancer (1 ≤50) & another Lynch* cancer, any age

Three persons with: (out to 2nd degree)
-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Lynch cancers: endometrial, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaceous adenomas



SYMPTOM CHECKLIST FOR WOMEN

Name: ______________________________ **Date:** ____________________

SYMPTOMS	NEVER	MILD	MODERATE	SEVERE
Please check symptoms you are experiencing				
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/ libido				
Difficulty in climaxing / achieving an orgasm				
Sleep problems				
Mood changes / irritability / tension				
Migraines / severe headaches				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Feeling cold all of the time				
Joint Pain				
Swelling all over the body				